COMPOUNDED PRESCRIPTION ORDER

DATE: _____

PRESCRIBER INFORMATION		
Practice Name		
Street Address		
City	State	Zip
Phone	Fax	

PATIENT INFORMATION		
Name		DOB
Street Address		
City	State	Zip
Phone	Email	
Allergies		

PHARMACY TO DISPENSE: TIRZEPATIDE 10 MG/ML INJECTION

Please choose Sig:	
▢	Inject 25 UNITS (2.5 mg) subcutaneously once a week for 4 weeks
▢	Inject 50 UNITS (5 mg) subcutaneously once a week for 4 weeks
▢	Inject 75 UNITS (7.5 mg) subcutaneously once a week for 4 weeks
▢	Inject 100 UNITS (10 mg) subcutaneously once a week for 4 weeks
▢	Inject 125 UNITS (12.5 mg) subcutaneously once a week for 4 weeks
▢	Inject 150 UNITS (15 mg) subcutaneously once a week for 4 weeks
▢	Inject _____ UNITS subcutaneously once a week for 4 weeks

Pharmacy to dispense appropriate volume and quantity of U-100 syringes/needles

DISPENSE: 1 MONTH SUPPLY **Refills: _____**

This table is for pharmacist reference.
Prescriber does not need to fill out this section.

UNITS PER WEEK	VIAL SIZE TO DISPENSE
10 - 25	1 mL
26 - 50	2 mL
51 - 75	3 mL
76-100	2 x 2 mL
101-125	5 mL
126-150	2 x 3 mL

Vial expires 28 days after first puncture by patient

PRESCRIBER SECTION	
I certify that the above patient does not have a family/personal history of Medullary Thyroid Cancer or a personal history of Multiple Endocrine Neoplasia.	
Prescriber Name	
Prescriber Signature	Date/Time

Form provided by Premier Drugstore - Fax to 770-675-7296